Instructions on how to complete the Application Form

Section A:

1. Complete **Section A** with the information of the person filing the grievance or appeal
2. Complete all parts in print letters

Section B:
1. Complete **Section B** with the information if the person, facility or provider related to the
grievance or appeal

Section C:
1. Complete **Section C** indicating a brief description of the facts
2. Certify with your signature and that of a witness (if applicable) your allegations

Section D: Will be completed by a Triple S Service Officer

This formulary can be sent by fax, email or by regular mail to the following address:

Grievances and Appeals Department
Triple-S Salud, Inc
PO Box 11320
San Juan, PR 00922-9905
Fax: 787-706-2866
Email: psgqa@ssspr.com

*** This formulary is available in other formats and languages. If you need additional information, call 1-800-981-1352 or TTY 1-855-295-4040 for audio impaired.**

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza,
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任何人。

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-981-1352 (TTY: 1-855-295-4040).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-981-1352 (TTY: 1-855-295-4040).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-981-1352 (TTY: 1-855-295-4040).

Vital Salud en tus manos GOBIERNO DE PUERTO RICO

ASES ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

GRIEVANCE NUMBER
(Central – Month – Year - # Assigned)

GRIEVANCE FORM

SECTION A	PERSONAL INFORMATION OF THE COMPLAINANT	
NAME (Print)	Telephone No.	Date Filed:
Address	Contract Number - - - -	Primary Physician/Provider Number (SSS)
	IPA's Number	Primary Physician/Provider Telephone No.

SECTION B	GRIEVANCE FILED AGAINST:	
Name	Contract Number	Primary Physician/Provider Number (SSS)

SECTION C	DESCRIPTION OF THE EVENTS RELATED TO THE GRIEVANCE (use attachments if necessary)
After reading the description on the events related to this grievance, I certify these are truthful and I fully agree with the provided details.	
Provider, Member or Representative's Signature	Witness Signature (if applicable)

SECTION D	GRIEVANCE CLASSIFICATIONS (to be completed by Triple-S Salud Official)
☐ 1. Access and availability	☐ 8. Service Delay
☐ 2. Undue collection charge	☐ 9. Collection charge measures
☐ 3. Denial of diagnostic testing, lab work or X-rays	☐ 10. Limitations to open selection
☐ 4. Denial of prescription	☐ 11. Internal Administrative Process
☐ 5. Denial of surgical procedure	☐ 12. Physician Patient Relation
☐ 6. Denial of Referral	☐ 13. Request adjustment on a delayed or denied case
☐ 7. Member's Rights	☐ 14. Advance Directives
Triple-S Rep. Name (Print)	Signature Triple-S Rep.

TRIPLE-S SALUD BlueCross BlueShield of Puerto Rico
Concesionario Independiente de BlueCross BlueShield Association
Centro de llamadas Vital 1.800.981.1352
www.sssvital.com
¿Ayuda con su Plan de Salud del Gobierno? ASES Línea libre de cargos 1-800-981-2737 TTY 787-474-3389

APPEAL NUMBER
(Central – Month – Year - # Assigned)

APPEALS FORMS

SECTION A	PERSONAL INFORMATION OF THE COMPLAINANT	
NAME (Print)	Telephone No.	Date Filed:
Address	Contract Number - - - -	Primary Physician/Provider Number (SSS)
	IPA's Number	Primary Physician/Provider Telephone No.

SECTION B	APPEAL FILED AGAINST:	
Name	Contract Number	Primary Physician/Provider Number (SSS)

SECTION C	DESCRIPTION OF THE EVENTS RELATED TO THE APPEAL (use attachments if necessary)
After reading the description on the events related to this appeal, I certify these are truthful and I fully agree with the provided details.	
Provider, Member or Representative's Signature	Witness Signature (if applicable)

SECTION D: DESCRIPTION OF EVIDENCE INCLUDED	
Triple-S Rep. Name (Print)	